SENATE BILL No. 908

Introduced by Senator Hernandez

January 26, 2016

An act to amend Sections 1374.21 and 1389.25 of the Health and Safety Code, and to amend Sections 10113.9 and 10199.1 of the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 908, as introduced, Hernandez. Health care coverage: premium rate change: notice: other health coverage.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care, and makes a willful violation of its provisions a crime. Existing law provides for the licensure and regulation of health insurers by the Department of Insurance.

Existing law prohibits, among other things, a change in premium rates for group health care service plan contracts and group health insurance policies from becoming effective unless a written notice is delivered as specified.

This bill would require that if the Department of Managed Health Care or the Department of Insurance determines that a group rate is unreasonable or not justified, the contractholder or policyholder would be notified by the health care service plan or health insurer in writing of the determination, and the contractholder or policyholder would be given 60 days to obtain health coverage from the existing coverage provider or another provider. During the 60-day period the contractholder or policyholder would continue to be covered at the prior rate. The bill also would exempt these circumstances from the requirement that an enrollment in or change of health care service plan

contract or health insurance policy be made during an open, annual, or special enrollment period.

Existing law prohibits, among other things, a change in premium rates for individual health care service plan contracts and individual health insurance policies from becoming effective unless a written notice is delivered as specified. Existing law, subject to certain provisions, requires a health care service plan or health insurer to allow an individual to enroll in or change individual health benefit plans as a result of specified triggering events for the purposes of a special enrollment period.

This bill would require that if the Department of Managed Health Care or the Department of Insurance determines that an individual rate is unreasonable or not justified, the contractholder or policyholder would be notified by the health care service plan or health insurer in writing of the determination, and the contractholder or policyholder would be given 60 days to obtain coverage from the existing coverage provider or another provider. During the 60-day period the contractholder or policyholder would continue to be covered at the prior rate.

This bill would also revise obsolete references and make other technical, nonsubstantive changes.

Because a willful violation of the bill's requirements with respect to health care service plans would be a crime, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

SECTION 1. Section 1374.21 of the Health and Safety Code is amended to read:

1374.21. (a) (1) A change in premium rates or changes in coverage stated in a group health care service plan contract shall not become effective unless the plan has delivered in writing a notice indicating the change or changes at least 60 days prior to the contract renewal effective date.

(2) The notice delivered pursuant to paragraph (1) for large group health plans shall also include the following information:

(A) Whether the rate proposed to be in effect is greater than the average rate increase for individual market products negotiated by the California Health Benefit Exchange for the most recent calendar year for which the rates are final.

(B) Whether the rate proposed to be in effect is greater than the average rate increase negotiated by the Board of Administration of the Public Employees' Retirement System for the most recent calendar year for which the rates are final.

(C) Whether the rate change includes any portion of the excise tax paid by the health plan.

(b) A health care service plan that declines to offer coverage to or denies enrollment for a large group applying for coverage shall, at the time of the denial of coverage, provide the applicant with the specific reason or reasons for the decision in writing, in clear, easily understandable language.

(c) (1) Notwithstanding subdivision (b) of Section 1357.503, if the department determines that a rate is unreasonable or not justified, the plan shall notify the contractholder of this determination and shall offer the contractholder coverage of no less than 60 days in order for the contractholder to obtain other coverage, including coverage from another health care service plan. During the 60-day period, the prior rate shall remain in effect to allow the purchaser the opportunity to obtain other coverage.

(2) The notification to the contractholder shall state the following in 14-point type:

"The Department of Managed Health Care has determined that the rate for this product is not reasonable or not justified. All health coverage offered to employers like you is reviewed to determine whether the rates are reasonable and justified. You have 60 days from the date of this notice to obtain coverage from this health plan or another health plan. During that time, the prior rate shall remain in effect. For small group purchasers, contact Covered California at www.coveredca.com for help in obtaining coverage."

(3) The notice shall also be provided to the solicitor for the contractholder, if any, so that the solicitor may assist the purchaser in finding other coverage.

SEC. 2. Section 1389.25 of the Health and Safety Code is amended to read:

1389.25. (a) (1) This section shall apply only to a full service health care service plan offering health coverage in the individual market in California and shall not apply to a specialized health care service plan, a health care service plan contract in the Medi-Cal program (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code), a health care service plan conversion contract offered pursuant to Section 1373.6, a health care service plan contract in the Healthy Families Program (Part 6.2 (commencing with Section 12693) of Division 2 of the Insurance Code), or a health care service plan contract offered to a federally eligible defined individual under Article 4.6 (commencing with Section 1366.35).

(2) A local initiative, as defined in subdivision ~~(v)~~ *(w)* of Section 53810 of Title 22 of the California Code of Regulations, that is awarded a contract by the State Department of Health Care Services pursuant to subdivision (b) of Section 53800 of Title 22 of the California Code of Regulations, shall not be subject to this section unless the plan offers coverage in the individual market to persons not covered by Medi-Cal or the Healthy Families Program.

(b) (1) No change in the premium rate or coverage for an individual plan contract shall become effective unless the plan has delivered a written notice of the change at least 15 days prior to the start of the annual enrollment period applicable to the contract or 60 days prior to the effective date of the contract renewal, whichever occurs earlier in the calendar year.

(2) The written notice required pursuant to paragraph (1) shall be delivered to the individual contractholder at his or her last address known to the plan. The notice shall state in italics and in 12-point type the actual dollar amount of the premium rate increase and the specific percentage by which the current premium will be increased. The notice shall describe in plain, understandable English any changes in the plan design or any changes in benefits, including a reduction in benefits or changes to waivers, exclusions, or conditions, and highlight this information by printing it in italics. The notice shall specify in a minimum of 10-point bold typeface,

the reason for a premium rate change or a change to the plan design or benefits.

(c) (1) Notwithstanding subdivision (c) of Section 1399.849, if the department determines that a rate is unreasonable or not justified, the plan shall notify the contractholder of this determination and shall offer the contractholder coverage of no less than 60 days to obtain other coverage, including coverage from another health care service plan. During the 60-day period, the prior rate shall remain in effect to allow the purchaser the opportunity to obtain other coverage.

(2) The notification to the contractholder shall state the following in 14-point type:

"The Department of Managed Health Care has determined that the rate for this product is not reasonable or not justified. All health coverage offered to individuals like you is reviewed to determine whether the rates are reasonable and justified. You have 60 days from the date of this notice to obtain coverage from this health plan or another health plan. During that time, the prior rate shall remain in effect. You may also contact Covered California at www.coveredca.com for help in obtaining coverage."

(3) The notice shall also be provided to the solicitor for the contractholder, if any, so that the solicitor may assist the purchaser in finding other coverage.

(4) The notice shall constitute a trigger event for purposes of special enrollment, as defined in Section 1399.849.

~~(c)~~

(d) If a plan rejects a dependent of a subscriber applying to be added to the subscriber's individual grandfathered health plan, rejects an applicant for a Medicare supplement plan contract due to the applicant having end-stage renal disease, or offers an individual grandfathered health plan to an applicant at a rate that is higher than the standard rate, the plan shall inform the applicant about the California Major Risk Medical Insurance Program (MRMIP) ~~(Part 6.5 (commencing with Section 12700) of Division 2 of the Insurance Code)~~ *(Chapter 4 (commencing with Section 15870) of Part 3.3 of Division 9 of the Welfare and Institutions Code)* and about the new coverage ~~options,~~ *options* and the potential for subsidized ~~coverage,~~ *coverage* through Covered

California. The plan shall direct persons seeking more information to MRMIP, Covered California, plan or policy representatives, insurance agents, or an entity paid by Covered California to assist with health coverage enrollment, such as a navigator or an assister.

~~(d)~~

(e) A notice provided pursuant to this section is a private and confidential communication and, at the time of application, the plan shall give the individual applicant the opportunity to designate the address for receipt of the written notice in order to protect the confidentiality of any personal or privileged information.

~~(e)~~

(f) For purposes of this section, the following definitions shall apply:

(1) "Covered California" means the California Health Benefit Exchange established pursuant to Section 100500 of the Government Code.

(2) "Grandfathered health plan" has the same meaning as that term is defined in Section 1251 of PPACA.

(3) "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued pursuant to that law.

SEC. 3. Section 10113.9 of the Insurance Code is amended to read:

10113.9. (a) This section shall not apply to short-term limited duration health insurance, vision-only, dental-only, or CHAMPUS-supplement insurance, or to hospital indemnity, hospital-only, accident-only, or specified disease insurance that does not pay benefits on a fixed benefit, cash payment only basis.

(b) (1) No change in the premium rate or coverage for an individual health insurance policy shall become effective unless the insurer has delivered a written notice of the change at least 15 days prior to the start of the annual enrollment period applicable to the policy or 60 days prior to the effective date of the policy renewal, whichever occurs earlier in the calendar year.

(2) The written notice required pursuant to paragraph (1) shall be delivered to the individual policyholder at his or her last address known to the insurer. The notice shall state in italics and in 12-point type the actual dollar amount of the premium increase and the

specific percentage by which the current premium will be increased. The notice shall describe in plain, understandable English any changes in the policy or any changes in benefits, including a reduction in benefits or changes to waivers, exclusions, or conditions, and highlight this information by printing it in italics. The notice shall specify in a minimum of 10-point bold typeface, the reason for a premium rate change or a change in coverage or benefits.

(c) (1) Notwithstanding subdivision (c) of Section 10965.3, if the department determines that a rate is unreasonable or not justified, the insurer shall notify the policyholder of this determination and shall offer the policyholder coverage of no less than 60 days in order to obtain other coverage, including coverage from another health insurer. During the 60-day period, the prior rate shall remain in effect to allow the purchaser the opportunity to obtain other coverage.

(2) The notification to the policyholder shall state the following in 14-point type:

"The Department of Insurance has determined that the rate for this product is not reasonable or not justified. All health coverage offered to individuals like you is reviewed to determine whether the rates are reasonable and justified. You have 60 days from the date of this notice to obtain coverage from this health insurer or another health insurer. During that time, the prior rate shall remain in effect. You may also contact Covered California at www.coveredca.com for help in obtaining coverage."

(3) The notice shall also be provided to the solicitor for the policyholder, if any, so that the solicitor may assist the purchaser in finding other coverage.

(4) The notice shall constitute a trigger event for purposes of special enrollment, as defined in Section 10965.3.

~~(c)~~

(d) If an insurer rejects a dependent of a policyholder applying to be added to the policyholder's individual grandfathered health plan, rejects an applicant for a Medicare supplement policy due to the applicant having end-stage renal disease, or offers an individual grandfathered health plan to an applicant at a rate that is higher than the standard rate, the insurer shall inform the

applicant about the California Major Risk Medical Insurance Program (MRMIP) ~~(Part 6.5 (commencing with Section 12700) of Division 2)~~ *(Chapter 4 (commencing with Section 15870) of Part 3.3 of Division 9 of the Welfare and Institutions Code)* and about the new coverage ~~options,~~ *options* and the potential for subsidized ~~coverage,~~ *coverage* through Covered California. The insurer shall direct persons seeking more information to MRMIP, Covered California, plan or policy representatives, insurance agents, or an entity paid by Covered California to assist with health coverage enrollment, such as a navigator or an assister.

~~(d)~~

(e) A notice provided pursuant to this section is a private and confidential communication and, at the time of application, the insurer shall give the applicant the opportunity to designate the address for receipt of the written notice in order to protect the confidentiality of any personal or privileged information.

~~(e)~~

(f) For purposes of this section, the following definitions shall apply:

(1) "Covered California" means the California Health Benefit Exchange established pursuant to Section 100500 of the Government Code.

(2) "Grandfathered health plan" has the same meaning as that term is defined in Section 1251 of PPACA.

(3) "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued pursuant to that law.

SEC. 4. Section 10199.1 of the Insurance Code is amended to read:

10199.1. (a) (1) An insurer or nonprofit hospital service plan or administrator acting on its behalf shall not terminate a group master policy or contract providing hospital, medical, or surgical benefits, increase premiums or charges therefor, reduce or eliminate benefits thereunder, or restrict eligibility for coverage thereunder without providing prior notice of that action. The action shall not become effective unless written notice of the action was delivered by mail to the last known address of the appropriate insurance producer and the appropriate administrator, if any, at least 45 days

prior to the effective date of the action and to the last known address of the group policyholder or group contractholder at least 60 days prior to the effective date of the action. If nonemployee certificate holders or employees of more than one employer are covered under the policy or contract, written notice shall also be delivered by mail to the last known address of each nonemployee certificate holder or affected employer or, if the action does not affect all employees and dependents of one or more employers, to the last known address of each affected employee certificate holder, at least 60 days prior to the effective date of the action.

(2) The notice delivered pursuant to paragraph (1) for large group health insurance policies shall also include the following information:

(A) Whether the rate proposed to be in effect is greater than the average rate increase for individual market products negotiated by the California Health Benefit Exchange for the most recent calendar year for which the rates are final.

(B) Whether the rate proposed to be in effect is greater than the average rate increase negotiated by the Board of Administration of the Public Employees' Retirement System for the most recent calendar year for which the rates are final.

(C) Whether the rate change includes any portion of the excise tax paid by the health insurer.

(b) A holder of a master group policy or a master group nonprofit hospital service plan contract or administrator acting on its behalf shall not terminate the coverage of, increase premiums or charges for, or reduce or eliminate benefits available to, or restrict eligibility for coverage of a covered person, employer unit, or class of certificate holders covered under the policy or contract for hospital, medical, or surgical benefits without first providing prior notice of the action. The action shall not become effective unless written notice was delivered by mail to the last known address of each affected nonemployee certificate holder or employer, or if the action does not affect all employees and dependents of one or more employers, to the last known address of each affected employee certificate holder, at least 60 days prior to the effective date of the action.

(c) A health insurer that declines to offer coverage to or denies enrollment for a large group applying for coverage shall, at the time of the denial of coverage, provide the applicant with the

specific reason or reasons for the decision in writing, in clear, easily understandable language.

(d) (1) Notwithstanding paragraph (3) of subdivision (b) of Section 10753.05, if the department determines that a rate is unreasonable or not justified, the insurer shall notify the policyholder of this determination and shall offer the policyholder coverage of no less than 60 days in order for the policyholder to obtain coverage from this health insurer or another health insurer. During the 60-day period, the prior rate shall remain in effect to allow the purchaser the opportunity to obtain other coverage, including coverage from another health insurer.

(2) The notification to the policyholder shall state the following in 14-point type:

"The Department of Insurance has determined that the rate for this product is not reasonable or not justified. All health coverage offered to employers like you is reviewed to determine whether the rates are reasonable and justified. You have 60 days from the date of this notice to obtain coverage from this health insurer or another health insurer. During that time, the prior rate shall remain in effect. For small group purchasers, contact Covered California at www.coveredca.com for help in obtaining coverage."

(3) The notice shall also be provided to the solicitor for the policyholder, if any, so that the solicitor may assist the purchaser in finding other coverage.

SEC. 5. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

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